



DEPARTMENT OF VETERANS AFFAIRS

8302-01

38 CFR Part 17

RIN 2900-AN98

Payment for Home Health Services and Hospice Care by Non-VA Providers.

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulation and internal policy documents concerning the billing methodology for non-VA providers of home health services and hospice care. The proposed rulemaking would include home health services and hospice care under the VA regulation governing payment for other non-VA health care providers. Because the newly applicable methodology cannot supersede rates for which VA has specifically contracted, this rulemaking will only affect providers who do not have existing negotiated contracts with VA. The proposed rule would also rescind internal guidance documents that could be interpreted as conflicting with the proposed rule.

DATES: Comment Date: Comments on the proposed rule must be received by VA on or before [Insert date 30 days after date of publication in the FEDERAL REGISTER].

ADDRESSES: Written comments may be submitted through www.Regulations.gov; by mail or hand-delivery to the Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue, NW, Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. Comments should indicate that they are submitted in response to “RIN 2900-AN98--Payment for home health and services and hospice care by non-VA providers.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment. This is not a toll-free number. In addition, during the comment period, comments may be viewed online at www.Regulations.gov through the Federal Docket Management Systems (FDMS).

FOR FURTHER INFORMATION CONTACT: Holley Niethammer, Fee Policy Chief, National Fee Program Office, Veterans Health Administration, Department of Veterans Affairs, 3773 Cherry Creek Dr. N., East Tower, Ste 495, Denver, CO 80209, (303) 370-5062. (This is not a toll-free number).

SUPPLEMENTARY INFORMATION: On December 17, 2010, VA published in the Federal Register a rule amending 38 CFR 17.56 to update VA’s payment methodology for in- and outpatient health care professional services provided at non-VA facilities, and other medical charges associated with non-VA outpatient

care, provided under 38 CFR 17.52 or 17.120. 75 FR 78901 (Dec. 17, 2010). In paragraph (a) of § 17.56, as amended, we state that the new methodology does not apply to “non-contractual payments for home health services and hospice care.” 38 CFR 17.56(a). As explained in the notice of final rulemaking, this exception is based on practical, administrative considerations, and not based on a policy decision that these services ought to be billed in a different manner. See 75 FR 78901. We explained:

Home Health Care and Hospice Care

[T]he pricing methodology adopted by this rule would be used in establishing payment rates for all non-VA inpatient and outpatient health care professional services and other outpatient services, including hospice care and home health services. However, in reviewing implementation strategies and internal procedural practices related to the payment of hospice care and home health services through means other than a contract, we have encountered significant practical problems that prevent immediate implementation of this new methodology. These problems relate to separate administration of hospice care and home health services by the Veterans Health Administration’s Office of Geriatrics and Extended Care, which uses separate methods for forming agreements for these services, and challenges regarding information technology systems necessary to move to the new [Centers for] Medicare [and Medicaid] rate, but do not relate to the actual payment amounts for these services. Such amounts would generally be unchanged by this rulemaking because the vast majority of these services are paid through a contractual mechanism (and are therefore exempted under § 17.56(a)(1)). However, we estimate that there may be about 100 providers who are not paid through a contractual mechanism and therefore who would have been affected by this rulemaking.

Given separate administration of hospice and home health services under separate VA guidance, we have determined that these providers did not receive adequate notice regarding the intended effect of the proposed rule or of the need for some delay in implementation of the rule so that VA may modify its systems. We will promulgate, as soon as possible, a proposed rule to make § 17.56, as revised by this notice, applicable to these providers. Therefore, we have added to paragraph (a) of the final rule an exception for these two services.

Id. at 78908.

This rulemaking would remove the exception so that the billing methodology in § 17.56 would apply to payments for home health services and hospice care. The reasons that we would make the billing methodology in § 17.56 applicable to these exempted groups were explained thoroughly in the proposed and final rulemakings that amended § 17.56. See 75 FR 7218 (Feb. 18, 2010); 75 FR 78901. We need not repeat them here. Indeed, in the proposed rule we specifically stated that that rationale should be applied to home health services and hospice care, noting that we intended to adopt the “Home Health Prospective Payment System” and “Hospice” Medicare schedules. 75 FR at 7219. It was not until the final-rule notice that we recognized a need to re-propose, for administrative reasons, making the methodology applicable to home health and hospice care.

By this proposed rule, we also notify providers of home health services and hospice care that by adopting § 17.56 methodology, VA would rescind all conflicting internal VA guidance that could be interpreted as providing an alternate billing methodology applicable only to these services. Due to VA’s historically separate administration of hospice and home health care from the other services affected by § 17.56, a VHA Handbook provides guidance specific to payments for non-VA home health services and hospice care. See Veterans Health Administration, U.S. Dep’t of Veterans Affairs, VHA Handbook 1140.3, Home Health and Hospice Care Reimbursement Handbook (Aug. 16, 2004). VHA Handbook 1140.3 establishes maximum reimbursement rates for non-VA

home health services and hospice care when a payment methodology has not been established under a negotiated contract, but also authorizes exemptions from these maximum rates to negotiate contracts with providers for home health services and hospice care. This Handbook states the following on page 3 regarding establishing maximum rates for home health services: “VA uses locally calculated, discipline-specific, Medicare LUPA [Low-Utilization Payment Amount] rates as the maximum cap for skilled home care and home health aide services. In those states that reimburse separately for homemaker services, VA’s rate will not exceed 110 percent of the established state rate for that home care agency or geographic area.” For establishing maximum rates for hospice care, the Handbook also states on page 3: “VA uses locally calculated, Medicare hospice payment rates as the maximum reimbursement rates to purchase a comprehensive package of bundled home hospice services.” These alternate pricing methodologies would be rescinded by this rulemaking. The prior final rule and this proposed rule are intended to prescribe an exclusive billing methodology for all covered services.

We explained in the final rule amending § 17.56 that we estimated only about 100 providers will be affected by this revision because under § 17.56(a)(1) any negotiated rate will prevail over the other methodologies set forth in § 17.56. See 75 FR at 78908. However, a more accurate estimate is that about 8400 providers will be affected. On average, each of these providers cares for 6 veterans at VA expense, and the potential revenue loss is \$1,346.28 per provider annually. In addition, these providers without negotiated contracts for payment

may benefit from the “phase-in” of the new rates, which is contemplated by the language in § 17.56(a)(2)(i), where VA will pay: “[t]he applicable Medicare fee schedule or prospective payment system amount (‘Medicare Rate’) for the period in which the service was provided...”. 38 CFR 17.56(a)(2)(i).

Comment Period

Although under the rulemaking guidelines in Executive Order 12866, VA ordinarily provides a 60-day comment period, the Secretary has determined that there is good cause to limit the public comment period on this proposed rule to 30 days. The application of the rates in § 17.56 to non-VA providers of home health services and hospice care was in fact proposed in February 2010. See 75 FR 7218. However, we exempted these services in the final rule for the administrative reasons discussed above, and indicated that we would soon propose once again to include them in § 17.56. See 75 FR 78901. Therefore, significant public notice has already been provided, as has the opportunity to comment on the applicability of § 17.56 to home health and hospice care payments. Accordingly, the Secretary has provided a 30-day comment period for this proposed rule.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in expenditure by State, local, or tribal

governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any given year. This rule would have no such effect on State, local, or tribal governments, or the private sector.

Paperwork Reduction Act

This action contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501 et seq.).

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action,” which requires review by the Office of Management and Budget (OMB), as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or

safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined and it has been determined not to be a significant regulatory action under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed regulatory amendment would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601 et seq. We estimate that about 8400 providers without negotiated contracts offer home health care or hospice care to veterans at rates that are equivalent to, or not significantly higher than, those offered by the proposed amendment. VA costs of purchased skilled home care were compared to Medicare Home Health Prospective Payment System (HH-PPS) reimbursement for a 60-day period. The average VA reimbursement level per veteran for a 60-day period was \$2,537.40 in FY 2010. The average Medicare reimbursement level for skilled home care per beneficiary was \$2,312.94 in FY 2010. This difference would mean that providers would receive \$3.74 less per day from VA for a 60-day episode of care.

On average, each of the 8400 providers cares for 6 veterans at VA expense, and the potential revenue loss would be \$1,346.28 per provider annually, an insignificant amount of revenue for these providers. This total would be less than 100 million dollars annually. Therefore, pursuant to 5 U.S.C. 605(b), this proposed amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on November 14, 2011, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Government programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing home care, Veterans.

Dated: November 16, 2011

Robert C. McFetridge,
Director of Regulation Policy and Management,
Office of the General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs proposes to revise 38 CFR Part 17 as follows:

PART 17 – MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, and as noted in specific sections.

2. Revise § 17.56(a) by removing “and except for non-contractual payments for home health services and hospice care”.

[FR Doc. 2011-29994 Filed 11/18/2011 at 8:45 am; Publication Date:
11/21/2011]